Maryland Health Care Reform Coordinating Council

Health Care Workforce Workgroup

White Paper

October 31, 2010

Charge

Recently released projections of physician supply and demand identify a national shortage of 90,000 physicians in ten years.[1] While more individuals will have health insurance when federal reform is fully implemented, their coverage will be meaningful only if they have access to health care providers able to meet their needs. Shortages in Maryland's health care workforce already exist, and will be exacerbated in the future by the increased demand for services resulting from reform, coupled with the increasing need for health services by an aging population. At the same time, there are trends in the health delivery system attempting to shift from acute to primary care, and from institutional to community-based settings, which may affect future workforce needs.

The Health Care Workforce Workgroup is charged with considering strategies to prepare the workforce for the future. The workgroup was directed to partner with the Governor's Workforce Investment Board (GWIB) to identify areas best addressed through collaboration with existing programs and initiatives.

Critical questions for this workgroup include:

1) What steps should Maryland take to ensure sufficient capacity in the health care delivery system to meet increased demand?
2) To what extent should Maryland use a broad range of tools to increase capacity and assure an adequate workforce, including fostering **educational and training** programs designed for the workforce of the future, changing **licensing policies**, supporting **recruitment and retention** strategies, and changing **liability laws and regulations**? Key themes that emerged from public comment are outlined below.
3) How can Maryland effectively compete for new federal funding opportunities, particularly for underserved areas?

Given the breadth of these issues, the workgroup was to first focus on the most immediate issues that Maryland will need to address for successful reform implementation in the next 12 months, particularly the issues that require legislation during the 2011 session of the General Assembly. In addition, the workgroup was to identify issues requiring further attention and decision-making.

Process

The Health Care Workforce Workgroup was co-chaired by Thomas McLain Middleton, Chairman of the Senate Finance Committee, and Wendy Kronmiller, Chief of Staff and Assistant Secretary of Regulatory Affairs, Department of Health and Mental Hygiene. There was no assigned membership. In an effort to be as inclusive as possible, participation in the workgroup was open to any interested party.

The workgroup met three times between September 2010 and October 2010. The goals of the first meeting were to review the charge and provide background information on recent efforts in Maryland to strengthen workforce capacity. The co-chairs solicited feedback on these recent efforts, including the gaps that this workgroup should address, and where additional momentum might be needed to advance past recommendations. The goal of the second meeting was to hear

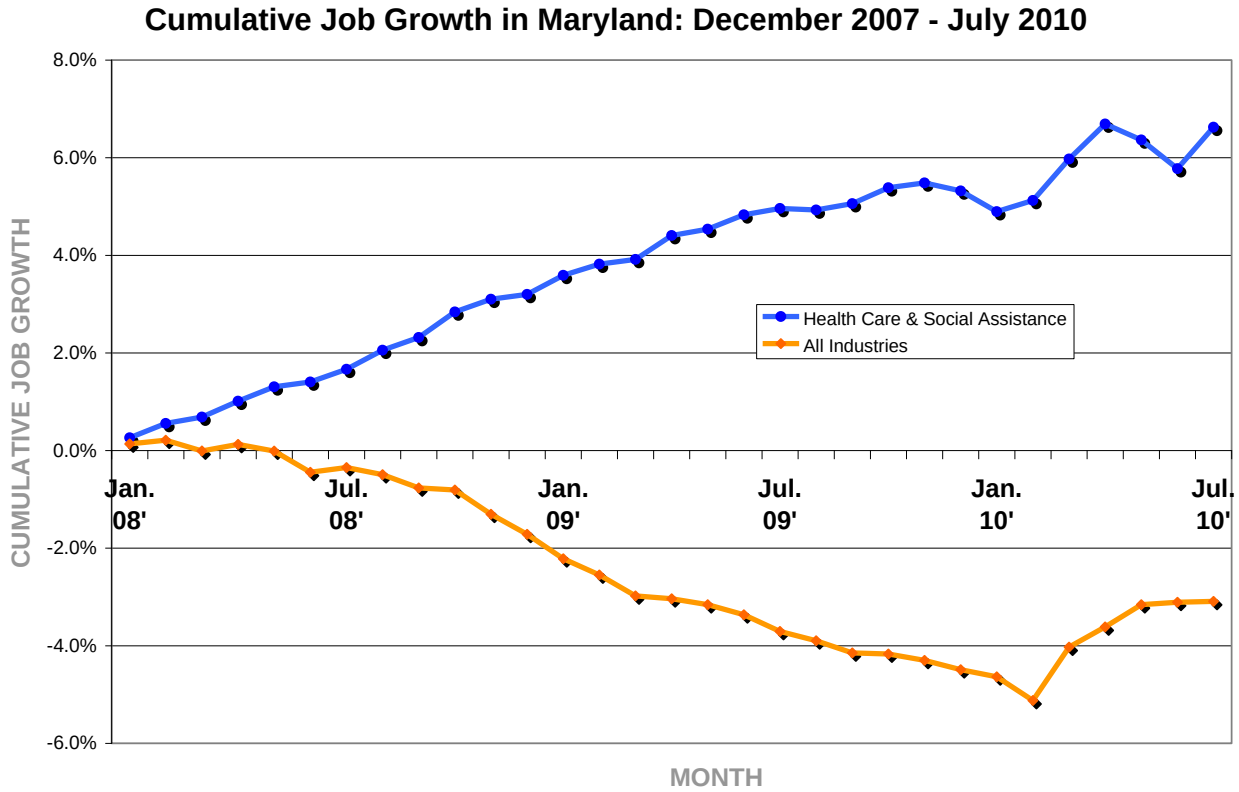
[1] Physician Shortages to Worsen without Increases in Residency Training. Association of American Medical Colleges. September 30, 2010.

from panels of educators, professionals, consumers, and providers hiring or contracting with professionals regarding potential tools for strengthening workforce capacity. In addition to the panels, individuals provided public comment on these topics. Written comments were also accepted via the HCRCC website. The third meeting was devoted to reviewing and gaining public input on the draft white paper of options based on input received.

Background

Multiple public entities in Maryland address workforce issues, including the Governor's Workforce Investment Board (GWIB), the Department of Health and Mental Hygiene (DHMH), the Maryland Higher Education Commission (MHEC), and the Department of Business and Economic Development (DBED). GWIB defines the chronic ailments of the health care workforce as the continuous need for trained workers, faculty capacity, lack of clinical sites, physical space, demographic changes, cultural competency, and funding.

The table below shows that between 2007 and 2010, health care and social assistance jobs grew in Maryland while there were declines in jobs in all other industries.



Data Source: Maryland Department of Labor, Licensing and Regulation

Despite these gains, Maryland's aging population puts pressure on the health care system from two ends: the overall population is aging and as a result requiring a greater volume of health services, at the same time that health care professionals are aging and retiring from the work force.

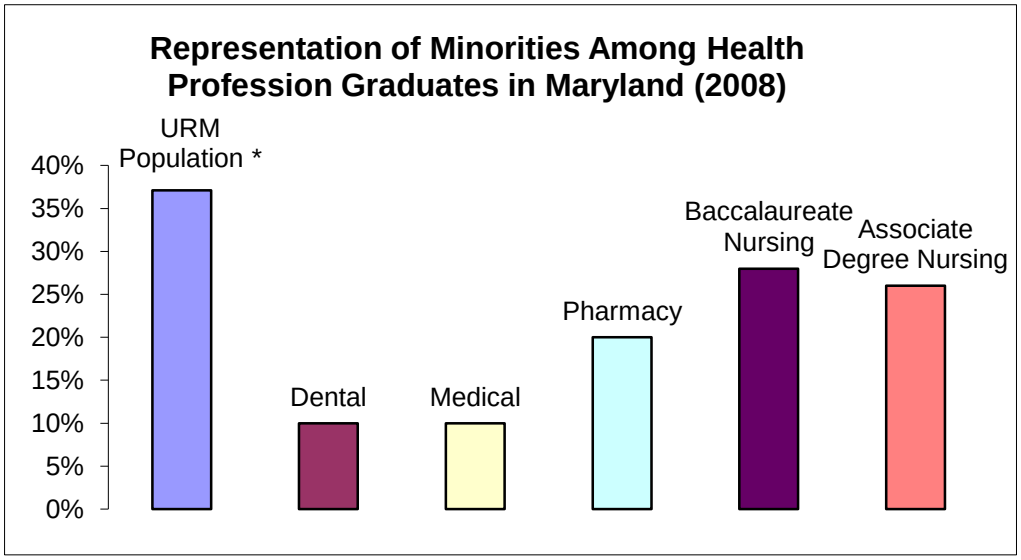
Data from the Maryland Department of Labor, Licensing, and Regulation (DLLR) show the health care professions with the greatest projected need between 2008 and 2018. These projections do not take increased demand from health reform implementation into account, and therefore likely understate need. The following table describes these trends.

Health Care Practitioner and Technical Occupations with the Most Projected Openings, 2008 to 2018

Title	Jobs in 2008	Projected Annual Openings	Projected Growth (2008-2018)
Registered Nurses	51,290	2,042	22.3%
Licensed Practical and Licensed Vocational Nurses	10,975	554	19.1%
Pharmacy Technicians	5,865	317	28.8%
Physicians and Surgeons, All Other	9,790	256	8.5%
Pharmacists	5,175	199	16.2%
Physical Therapists	3,905	180	33.9%
Radiologic Technologists and Technicians	4,220	141	19.0%
Medical and Clinical Laboratory Technologists	4,345	137	12.4%
Dental Hygienists	2,405	112	26.0%
Emergency Medical Technicians and Paramedics	3,840	110	8.2%

Source: Maryland Department of Labor, Licensing, and Regulation

In particular, there is a need for greater diversity in Maryland's health care workforce. The chart below shows the percentage of Black/African American, Native American, and Hispanic/Latino health profession graduates in 2008, compared to the percentage of Blacks/African Americans, Native Americans, and Hispanics/Latinos in Maryland's overall population. These populations are under-represented in the health professions relative to their proportion of Maryland's general population.



* The term "under-represented minorities" (URM) refers to Black/African American, Native American and Hispanic/Latino health profession graduates.
Source: Maryland Vital Statistics, ADEA, AAMC, AACP, MHEC.

Health care workforce capacity has been studied previously in Maryland, with multiple past task forces and reports. The goal of the workgroup is to build upon previous efforts. Some of the key reports include the Task Force on Health Care Access and Reimbursement (HCAR)[2], established by Senate Bill 107 and issued in December 2008; the Task Force to Review Physician Shortages in Rural Areas[3], established by Senate Bill 459 and also issued in December 2008; the Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals, established by House Bill 524 and issued in November 2007; and the Maryland Physician Workforce Study[4], commissioned by the Maryland Hospital Association and MedChi, and issued in April of 2008.

These reports focused on physician workforce, and shared the following commonalities. Critical areas of concern statewide include primary care, emergency medicine, and obstetrics. Urban areas have more adequate overall physician supply, but within urban areas special attention is needed for populations with limited access. Rural areas and outer suburban areas require special attention to primary care and specialty care capacity. Concerns were raised about the adequacy of reimbursement, and the need for administrative simplification. Better medical management and new models of care, such as the patient centered medical home, were viewed as having the potential to alleviate shortages. Better data are needed on workforce supply. Lastly, there was a call for better coordination of existing resources. The 2007 Annual Report of the Statewide Commission on the Shortage in the Health Care Workforce[5] also highlighted the importance of coordination, and addressed the need to develop faculty, consider reciprocity, and promote diversity in the health care workforce. This Commission sunset in 2008.

[2] www.dhmh.maryland.gov/hcar/pdf/jan09/HCAR_Final_Report.pdf
[3] www.mlis.state.md.us/2009rs/misc/ReviewPhysicianShortages.pdf
[4] www.mhaonline.org/workforce/physicians
[5] www.dhmh.maryland.gov/mscshw/pdf/MSCSHW_2007Annual%20Rpt_Jan2008.pdf

Diversity in the health workforce was also addressed by the recommendations set forth by the Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals. The Workgroup's recommendations related to the need to facilitate the licensure or certification of foreign-born and foreign-trained mental health professionals to the full scope allowed by State and Federal law; and development of training programs and educational materials and other initiatives to enhance the cultural competency of all mental health professionals and enhance consumer access to culturally-appropriate mental health services.

Maryland's attention to health care workforce capacity has resulted in the implementation of multiple initiatives in recent years. Legislation has expanded the roles of nurse practitioners, physician assistants, pharmacists, and dental hygienists, and has addressed reimbursement by providing primary care bonus payments for after-hours and weekend care, and setting floors on HMO payments to non-contracting providers. Legislation in the past Session created a patient centered medical home pilot, to be launched in 2011. In the past Session the General Assembly passed Assignment of Benefit legislation that allows a patient's out-of-network provider to be paid directly (assignment of benefits) if that provider does not balance bill the patient. The bill also provides for increased reimbursement for non-preferred providers that fall under this agreement. In 2009, a Maryland loan assistance repayment program (LARP) was authorized, but State funding has been unavailable and implementation has stalled.

Financial support for nursing recruitment, retention, and education capacity continues to be provided through the Nurse Support Programs, funded through hospital rates. This initiative is administered by MHEC. The Nurse Support Program II provides approximately $17.7 million for multiyear projects from 2007 through 2012.[6] MHEC administers a number of additional student financial assistance programs, including the Workforce Shortage Student Assistance Grant Program to support students going into the fields of human services, nursing, public service, and physical and occupational therapy; the Loan Assistance Repayment Program for practicing nurses; the Graduate Nursing Faculty Scholarship and Living Expenses Grant Program to assist graduate nursing students to become nursing faculty at a Maryland higher education institution; and the Health Personnel Shortage Incentive Grant Program to support post-secondary institutions to enhance or expand programs in health occupations experiencing personnel shortages in Maryland. Other smaller MHEC programs target physician assistants, nurse practitioners, nurses, and optometrists. In recent years the Workforce Shortage Student Assistance Grant Program has experienced reductions in funding; annual funding fell from approximately $3 million FY 2008 to $1.25 million in FY 2011.

Increases to Medicaid physician and dental fees in past years have improved the reimbursement environment. Other efforts to strengthen workforce capacity have focused on telemedicine, transitioning military health care providers to the civilian workforce, physician quality reporting, and improved physician workforce data collection. The Maryland Health Quality and Cost Council is overseeing a multi-agency initiative leading to the establishment of a comprehensive telemedicine system in Maryland. A new Maryland Alliance to Transform the Health Professions is working to expand the diversity of the health care workforce. The DHMH Office of Minority Health and Health Disparities (MHHD) is developing and strengthening partnerships

[6] A Quick Guide to Nurse Support Programs I and II. http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/NurseSupportPrograms/NSP_QuickGuide.pdf.

with Maryland's health occupations boards, hospital systems, community colleges and universities to address workforce diversity and cultural competency under a federally-funded State Partnership Grant.

Additional initiatives include the Welcome Back Center, a program of the Montgomery County Department of Health and Human Services, which helps foreign-trained nursing professionals enter the Maryland health care workforce. The Maryland Hospital Association is leading the development of a Baltimore regional pilot adapted from this program. The Maryland Hospital Association's *Who Will Care?* Campaign has raised more than $17 million in private donations to help double the number of nursing graduates by 2016. In addition, the Maryland State Department of Education, the Maryland Area Health Education Centers (AHECs), local workforce investment boards, and other programs promote technical and health care training throughout the education system.

Public Input

The workgroup received close to 50 sets of comments, from individuals as well as coalitions. Workgroup comments echoed issues raised in public comments provided to the full HCRCC and summarized in the July 2010 Interim Report. The synthesis of workgroup comments is organized according to the major tools available to strengthen workforce capacity.

Perspectives were provided from across the health care delivery system, including physicians, nurses (advanced practice nurses, registered nurses, and others), physician assistants, dentists, occupational therapists, hospitals, community health centers, mental health providers, addictions providers, providers for people with developmental disabilities, public health workers, and others. The Workgroup also received comments from groups representing consumer and community interests.

It is essential to take into consideration the diverse needs of Maryland's population. The scope of the workgroup includes general health care workforce needs, as well as areas or populations for which shortages are exacerbated. These include rural areas, vulnerable populations such as those with low income, limited English proficiency, or racial and ethnic minorities experiencing health disparities.

Education and Training

The same key barriers to educating and training the workforce of the future were identified by a number of groups. These were limited financial assistance for full-time and mid-career part-time students, and graduate and professional students, including loan assistance repayment, tuition remission, and scholarships; the need for more faculty, and the competitive salaries and incentives to attract them; limited physical capacity of schools; and the need for more clinical training sites and incentives to attract more preceptors. These were cited as barriers to training a variety of health professions, including physicians, nurses, physician assistants, dentists, pharmacists, social workers, and allied health professionals.

There was agreement that support is needed for new models of training to advance the goals of health reform. These should emphasize multidisciplinary, coordinated team approaches, enhance understanding of the roles of team members, and train professionals to leverage health

information technology. Team approaches support optimal delivery of care by fully using the skills and knowledge of each team member. It was also suggested that public health principles be integrated into health professional education programs.

Strategies for education and training can target almost the full life spectrum. Educational planning to attract individuals to health fields could begin in elementary and secondary education. "Grow your own" programs may be especially important to develop workforce in rural areas, given that students are more likely to be committed to those areas. The Maryland Area Health Education Centers (AHECs) provide some models for this approach. Training programs are needed for health workers in the field to upgrade skills and advance up a career ladder. Initiatives to attract health professional retirees from health professions to work as instructors are one means to address needs for faculty.

Special attention was paid to the need for a health care workforce that is culturally and linguistically representative of the communities served. Studies show that health professionals from racial and ethnic minority groups are much more likely to practice in underserved areas. It was suggested that historically black colleges and universities would play a key role in training health professionals if enhanced support were available.

The Affordable Care Act provides funding opportunities to increase educational capacity. Smaller schools may need technical assistance on grant writing and project implementation in order to leverage these funds.

Efficient Use of Workforce Resources and Changes to Licensing Policy

More efficient use of existing workforce resources was raised by many as a way to meet increased demand for health care. Promotion of a team approach to providing care was cited as one means of increasing efficiency. The team approach recognizes the important role of the professional and graduate degree health care workforce as well as allied health providers, including speech therapists, occupational therapists, respiratory therapists, case managers, and patient navigators/community health workers. Other suggestions included fostering development of larger community-based integrated delivery systems, and investment in integrated and interoperable information technology systems that incorporate public health. There was interest in incentives for all primary care providers to adopt electronic health records. It was recommended that telehealth be recognized as a solution to respond to workforce shortages in rural and underserved areas, particularly for mental health services, and that any reimbursement or legal impediments to telehealth be explored.

Several groups advocated for regulatory and structural changes to allow nurse practitioners and physician assistants to practice at the full extent of competencies and current licensure. The participation of nurse practitioner-managed practices in patient centered medical home pilots, and changing Medicaid policy to increase the role of physician assistants, were examples. A key message of a recent Institute of Medicine Report, *The Future of Nursing: Leading Change, Advancing Health*[7] is that nurses should be allowed to practice to the full extent of their education and training**.**

[7] www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

Credentialing practices were cited as barriers to practice for nurse practitioners, physician assistants, and behavioral health providers. It was suggested that insurers be encouraged or required to credential nurse practitioners as primary care providers. Beyond credentialing, claims payment and utilization authorizations were described as lengthy, time-consuming, and burdensome. It was suggested that administrative requirements be streamlined, with greater uniformity across payers.

Other ideas included increasing the number of hospital and school based primary care clinics, with the goal of reducing unnecessary use of emergency rooms. It was suggested that current trends in the health care market, such as retail clinics, increase fragmentation and raise a danger of reducing efficiency by running counter to the medical home model.

Some raised concerns about the effect of "degree creep" and increasing licensure requirements on limiting access, for example for respiratory therapists. Representatives of nurse practitioners, physician assistants, dental hygienists, and pharmacists expressed interest in revisiting scope of practice to expand their responsibilities. There was discussion of the current structure to resolve scope of practice differences among the professional Boards, and the need to consider an evidence-based, neutral manner to evaluate competing scope of practice decisions. The need for new training and licensure for anesthesiologist assistants was suggested. It should be noted that the Maryland State Board of Dental Examiners' initiatives to expand dental workforce capacity include new responsibilities for dental hygienists, and the Board is considering support of licensure reciprocity across states for volunteer dentists. The Board of Social Work is promulgating regulations permitting "licensure by endorsement" under many circumstances for social workers licensed in other states. There was a call for cross-state licensure reciprocity or endorsement for more professions, specifically for short-term needs such as call coverage.

Others counseled more caution with scope of practice changes. It was recognized that while a change in scope of practice may be appropriate in some instances, it is imperative that any change in scope of services to be provided also articulates how these services are coherently delivered in the context of the patient's total care requirements. It was suggested that clear delineation of roles is needed.

The complexity and length of time to licensure were cited as current barriers to expanding the health care workforce.

Recruitment and Retention

The need to attract more individuals to primary care professions, and to retain professionals in Maryland, was the subject of much discussion. Given national shortages in primary care, it was stated that Maryland has to compete nationally to attract and retain primary care physicians. Maryland's high cost of living, low level of reimbursement, and challenging liability climate were cited as barriers. Reimbursement was a major issue raised by many types of health care professionals. It was noted that services follow the dollar in health care delivery systems, and primary care providers face an income gap because the current system favors specialty procedures over primary care. Inadequate Medicaid reimbursement levels and the uncompensated cost of case management contribute to the income gap. Concerns were raised

about the ability to recruit Medicaid providers once the Medicaid expansion is fully implemented. When individuals cannot access Medicaid providers they use local health departments and other public health programs to obtain care. It was suggested that therefore there is a need to maintain funding for public health safety net programs until it becomes clear that Medicaid has sufficient capacity to serve existing and newly eligible enrollees.

The nurse practitioner and physician assistant communities stated that the differentiation in reimbursement levels between those professions and physicians acts as a major barrier to access. For example, nurse practitioners are limited from opening their own practices because reimbursement at 85% of the rate of physicians is not a financially viable business model.

In addition to increased reimbursement levels, potential solutions to attracting and retaining providers in the primary care field include enhancing practice environments through practice expense reductions, administrative streamlining, support for health information technology, and greater access to telehealth.

Input regarding recruitment and retention of allied professions identified additional challenges, beyond just the adequacy of wages. Particularly in rural areas, allied professionals may need support for transportation or childcare. Many allied workers are uninsured, and face difficulties accessing pre-employment physicals or general preventive care.

Special attention is needed for the field of behavioral health. The mental health and addictions fields have faced high turnover and vacancy rates because of uncompetitive salaries and stigma. Because of new federal parity requirements and the expansion of Medicaid eligibility, a large increase in demand for behavioral health services is anticipated. This will exacerbate existing pressure on the behavioral health workforce, particularly for adults and children in need of the type of high-intensity care currently provided by the public behavioral health system, and for a workforce which can meet the needs of individuals with co-occurring mental health, substance abuse, and other chronic conditions. It was suggested that certain behavioral health providers be reimbursed for preventive and in-home services. Better information is needed on the current supply of and demand for a range of behavioral health providers by geographic area.

Advocate for Federal Change

It was suggested that Maryland advocate for federal change to increase the role for nurse practitioners, others in the nursing profession, and physician assistants. Current areas of limitation include the ability to prescribe buprenorphine and to order Medicare home health services. Maryland could also advocate for federal funding to advance education and training programs, including clinical simulation and targeting of diverse populations, and health information technology.

Options

Different options for the HCRCC to strengthen Maryland's health care workforce capacity are described below. These options are shaped in part by the Committee's charge to focus on the most immediate issues presented by health care reform. Some of the options entail specific activities that could begin in the short term, and others require further input from stakeholders and additional review. Options are organized around these two categories. They are *not*

numbered by order of priority. The options tend not to have a firm deadline for implementation, but it is in the best interests of successful health reform implementation to begin work on these options quickly. The timeline for increasing the number of practicing health care professionals can be lengthy, particularly when talking about education and training approaches to develop future providers.

Short-Term Activities

1. Revisit Maryland Loan Assistance Repayment Program Funding

Given the substantial student debt incurred by new physician graduates and the income gap between primary care and specialty physicians, there is wide support for financial assistance incentives to attract more physicians to primary care. As noted above, in 2009 the Maryland General Assembly authorized MHEC and DHMH to establish a new physician loan repayment program. Physicians practicing in a variety of settings in a DHMH-defined health professional shortage area would be eligible. Because the program would rely on state and not federal funds, the State would have flexibility to define shortage areas. The original plan for funding required federal approval, which Maryland has not received. One option for the HCRCC is to revisit the funding plan with the federal government, given the new context created by health reform. Stakeholders expressed interest in expanding this program beyond physicians to other health care professional students, as well as exploring additional sources of funding, for example a small portion of licensure fees.

2. Comprehensive Workforce Planning

Many different past initiatives have studied Maryland's health care workforce needs and provided recommendations for strengthening capacity. These efforts have tended to focus on specific categories of health professionals or geographic areas within Maryland. Health reform provides the impetus for a more comprehensive approach to planning. There is a need for better data to identify primary care shortage areas and target strategies, and for evaluation of efforts to understand the effectiveness of different strategies. Data and evaluation needs should be addressed through the planning process. It was suggested that information is needed on the numbers, types, and diversity of health professionals currently employed, where they are employed, and in what roles and what types of activities they perform. Data are also needed on the numbers, types, and diversity of health professional students in the educational pipeline, including allied health training programs.

The planning process should ensure the inclusion of stakeholders who represent and serve the needs of diverse communities, health professionals, health professions students, and institutions to adequately address the primary care shortage issues that exist in underserved areas in the state. Attention to behavioral health is important to these efforts. Retired health professionals would provide an additional perspective to the planning process. Local Health Departments, Community Health Centers, Federally Qualified Health Centers, School-Based Health Clinics, and community based organizations could also be incorporated in the planning process. It was suggested that this effort coordinate with existing efforts to develop a "Primary Care Access Plan" to identify the populations in need of services as well as the current resources available to meet the needs and the resources required to improve access to primary care services, as well as diagnostic, ancillary and specialty care services. To the extent possible, behavioral health

workforce assessments and regional variations should also be a part of this process.

GWIB was recently awarded a one-year, $150,000 State Health Care Workforce Development Planning Grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), through funding made available via the Affordable Care Act. The purpose of the grant is to establish a high-level health care workforce steering committee composed of GWIB Board Members that will undertake a rigorous planning process leading to development of the ten-year health care workforce expansion blueprint, "Preparing for Reform: Health Care 2020," which is designed to increase the primary care workforce by ten to 25% over a ten year period. Building on its well-established sector initiatives model, the GWIB will collaborate with a broad network of health care industry leaders, the education community, including two- and four-year institutions of higher education, graduate and professional schools, and the public workforce system to train new workers to meet the primary care workforce need resulting from the federal legislation.

The year-long GWIB grant should be the beginning of the comprehensive planning process for assessing how health reform affects workforce supply and demand within Maryland, particularly for primary care. Information on workforce supply and demand may inform consideration of how to increase the efficiency of the workforce through structural, policy, and regulatory changes, as well as considering evidence for licensing changes. The GWIB grant is one of several efforts to strengthen the health care workforce in anticipation of health reform.

3. Improve Coordination of Existing Resources

As mentioned above, a number of State entities are active in addressing health care workforce capacity needs. Recommendations to coordinate ongoing health care workforce issues in Maryland have been issued previously. There is a continued need for this, especially as the climate changes with health reform. The GWIB planning grant may provide a natural opportunity for better coordination.

Coordination efforts should also facilitate development of viable partnerships among both governmental and non-governmental entities engaged in health care workforce initiatives. Increased partnership-building could allow for increased efficiency in utilization of existing resources and greater prospects of successful grant awards through public and private funding sources.

Health care institutions should be heavily involved in any efforts to coordinate existing resources and develop partnerships that have the potential to improve the health outcomes of the local communities being served. For example, publicly-funded health care institutions' fulfillment of community-benefit obligations pertaining to diversity and cultural competency could provide an impetus for greater development of meaningful institutional partnerships with other entities and resources in the community. Health care institutions and other local entities are engaged in serving the needs of the same communities and populations.

4. Explore Licensure Process Improvements

Several ideas arose for strengthening the workforce through the licensure process and approaches at the level of the individual professional boards. These are listed below. There is also a need to

convene the different professional boards together in an effort to review evidence for scope of practice changes. Additional staffing would help with coordination, but it is feasible that existing resources would be sufficient with greater prioritization and accountability.

- Explore Shortened Licensure Process or Reciprocity: A review of professional licensure laws could explore options for greater efficiencies in licensure processes, including options for the implementation of reciprocity for individuals licensed in other States. Licensure qualifications may not be standardized across states, and these efforts must take care to protect patient safety and standards of quality.

- Incentivize Volunteerism: The number of health care professionals volunteering in underserved areas could be increased through the provision of incentives. One potential incentive is fulfillment of requirements for continuing education. The professional boards could promulgate regulations encouraging volunteer work in underserved areas as a means of fulfilling continuing education requirements.

- Require Cultural Competency Training: Promoting cultural competency can help to address disparities in health experienced by racial and ethnic minorities. The professional boards could require cultural competency training. Training programs should be evidence-based.

5. Pursue Demonstration Program to Evaluate Alternatives to Current Medical Tort Litigation

One of the factors cited in attracting and retaining primary care physicians to Maryland is the liability climate. The Affordable Care Act creates state demonstration programs to evaluate alternatives to current medical tort litigation. Each state applying for a grant must demonstrate how the proposed alternative:

- makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;
- encourages the efficient resolution of disputes;
- encourages the disclosure of health care errors;
- enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;
- improves access to liability insurance;
- fully informs patients about the differences in the alternative and current tort litigation;
- provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;
- would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and
- would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

States must establish a scope of jurisdiction for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. The scope cannot be based on a health care payer or patient population. The federal government will give preference to states that develop the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts. Preference will also be given to proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and that are likely to improve access to liability insurance.

The HCRCC has established a process for coordinating Affordable Care Act funding opportunities among State agencies. Applying for and initiating this demonstration program may help make Maryland more competitive nationally when vying for primary care physicians. Suggestions related to medical tort litigation received by the workgroup include strengthening apology provisions, enacting Good Samaritan provisions, and creating a pilot medical care track within the judicial system.

6. Facilitate Medical Malpractice Coverage for Volunteers

Medical malpractice coverage can create barriers for providers to volunteer in community settings. One solution may be to encourage hospitals, health systems, and insurance carriers to provide coverage for volunteer providers in community settings. This currently takes place on an ad hoc basis. A more structured system could increase the volume of volunteer providers in underserved areas.

Need for Further Input and Additional Review

7. Streamline Credentialing

Past steps have been taken to streamline provider credentialing, and further progress is needed. One option is to convene public and private insurers in Maryland with provider groups to review current credentialing practices and identify opportunities to further minimize unnecessary administrative burdens. It was suggested that a council of all stakeholders be established to recommend revised credentialing practices.

8. Facilitate Clinical Training in the Community

Steps can be taken to increase clinical training and residency opportunities in the community. This could address undergraduate and master's level training as well as post-licensure and post-graduation residencies. Opportunities might include physician residencies, nurse practitioner preceptorships, social work internships, and clinical training placements for all health care professions.

Increasing the availability of clinical training opportunities in the community for health professional students early in their educational careers may cultivate the interest of medical, nursing, and other health professional students in practicing in primary care and underserved areas. Community-based providers sometimes find it challenging to accommodate students, as it can be resource-intensive to create meaningful learning opportunities and provide appropriate supervision and coaching. The HCRCC may choose to initiate discussions with educational

institutions and community-based providers, including behavioral health providers, on ways to increase clinical training opportunities and overcome obstacles to clinical training placements, for example by developing a standardized agreement between community-based providers and schools.

The Affordable Care Act provides funding for "Teaching Health Centers" which are defined as ambulatory care programs with primary care residencies. This funding could represent a promising opportunity for community-based providers to establish their own residency programs. Currently, only hospitals can directly receive Graduate Medical Education (GME) payments through Medicare. However, in order to receive funds, providers must already be accredited by the Accreditation Council for Graduate Medical Education. The accreditation process is extensive and resource intensive. Support is needed for efforts to identify and obtain sources of funds that allow community-based providers to become accredited. Partnerships between community-based providers and hospitals accredited for GME offer another path to establishing more primary care residency rotations. While there is already activity in this area, an option is to convene a larger group of community-based providers and hospitals to create a more structured process for developing partnerships.

The Affordable Care Act promotes the establishment of "residency" style training for advanced practice nurses by establishing five demonstration projects. The projects award funds to qualified nursing schools and hospitals. There is also a provision for grant funding for a one-year training program for family practice nurse practitioners at a Federally Qualified Health Center (FQHC). Both of these grant opportunities may offer Maryland the opportunity to expand training opportunities for advance practice nurses. The HCRCC may encourage partnerships with schools of nursing and health organizations to pursue these opportunities. Resources and partnerships also could be identified to increase the integration of pharmacists, dentists, and behavioral health professionals in community-based primary care settings, through residencies and other training opportunities.

Such training programs should include education and clinical experience aimed at facilitating health professionals' development of skills in cultural competency and sensitivity, and the ability to navigate patient-provider discordance in language and health literacy. Inter-professional training models should also be encouraged. Special effort should be made to ensure that these clinical training opportunities are extended to health profession students who reside in rural and other medically-underserved areas, and students who are from racial and ethnic minority communities.

9. Maximize Opportunities for Non-Traditional Paths to Health Workforce Development

Increased effort could be made to identify and maximize the utilization of non-traditional channels to increase the health professions pipeline and practicing workforce. Many Marylanders are living longer in good health and have valuable contributions as retired health professionals. A well-organized program to bring these individuals back into the health care workforce could be beneficial to all.

Additional resources and partnerships could be identified to scale up and expand current programs dedicated to facilitating foreign-trained health professionals to enter Maryland's health

care workforce. A large pool of potential participants in Maryland's health workforce currently reside in Maryland and have a full range of health professions skills that are not being utilized due to barriers and challenges related to navigating the licensure and certification process.

As an extension of community-based clinical providers (whose training is discussed above), opportunities for establishing a lay network of community-based health workers could be considered to effectively link consumers to health information and services. Such a network of lay health workers recruited from within the respective communities being served would help to increase the likelihood that medically underserved residents gain access to appropriate and timely health information and primary care services. Lay health workers also represent a potential pool of future clinical and allied health providers.

Efforts to establish non-traditional paths into the health care workforce should consider educational needs to promote expertise and appropriate skills mix across the workforce. Partnerships developed to address Maryland's health care workforce issue could heavily involve the state's system of community colleges, particularly as they play a key role in moving students along the health professions and allied health pipelines. Increased efforts are needed to expand and/or create beneficial and effective partnerships between community colleges, historically black colleges and universities, and other universities in the state. Such partnerships also would be valuable in developing solutions to address a major problem in the health professions pipeline—high school drop-out and low performance issues. Solving problems that are impacting the foundation of the health professions pipeline requires a statewide effort to address this crisis in Maryland. A concerted effort to address Maryland's education and health professions pipeline crisis can best be handled through a coordinated partnership of State agencies, community organizations, and institutions dedicated to addressing the issues of education, health, employment, housing, public safety, criminal justice, and others.

10. Continue to Improve Medicaid Reimbursement Rates

Significant progress has been made in recent years to increase levels of Maryland's Medicaid reimbursement rates, in both the fee-for-service and managed care systems. The Health Care Provider Rate Stabilization Fund created in 2005 allocated funds to the Medicaid program to increase rates annually. For FYs 2006 through 2009, the Medicaid program convened stakeholders to discuss how best to apply rate stabilization funds to increase Medicaid fees. The group first identified areas experiencing access problems or where there were equity issues, and then recommended fee increases across all procedure codes. By FY 2009 Medicaid rates had been raised to approximately 83% of Medicare rates. Due to budget restrictions, certain physician fees were reduced in FY 2010 and FY 2011. Medicaid fees are currently at 80% of Medicare rates for almost all procedure codes. Fees for procedures that are commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians pay greater than 80% of the Medicare rate in order to maintain access to care. As Medicaid expands under the Affordable Care Act, covering a larger portion of the population, it will be even more important to have adequate Medicaid reimbursement. Part of workforce planning should include a plan for improving Medicaid reimbursement rates as the economy improves. It should be noted that effective January 1, 2013 through December 31, 2014, the Affordable Care Act increases Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate, financed with 100% federal funding.